

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-045642

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 352 Primary Registration District No. _____ Registrar's No. 98

FILED NOV 19 1962

1. PLACE OF DEATH

a. COUNTY

Taney

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN BransonLength of stay in 1b
12 daysc. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION Skaggs Hosp.Inside Limits
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Okla.

b. COUNTY Kay

c. CITY
OR TOWN

Blackwell

Inside Limits
Yes ☒ No ☐d. STREET ADDRESS (If outside, give location)
538 W. McKinleyReside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Middle

Last

JAMESON

McGREGOR

BURROWS

4. DATE
OF DEATH

Month

Day

Year

Nov. 11, 1962

5. SEX
male6. COLOR OR RACE
white7. Married ☒ Never Married ☐
Widowed ☐ Divorced ☐8. DATE OF BIRTH
2/6/18939. AGE (last birthday)
69IF UNDER 1 YEAR
Months 9 Days 10IF UNDER 24 HR
Hours Min.10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)
construction10b. KIND OF BUSINESS OR INDUSTRY
well drilling11. BIRTHPLACE (City and state or country)
Davenport, Iowa12. CITIZEN OF WHAT COUNTRY
USA

13a. FATHER'S NAME

Andrew Burrows

13b. MOTHER'S MAIDEN NAME

Louisa Vetter

14. NAME OF HUSBAND OR WIFE

Henrietta Burrows

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
No16. SOCIAL SECURITY NO.
none17. INFORMANT
James Burrows Golden, Mo

Address

18. CAUSE OF DEATH (Enter only one cause per line for
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral Embolus
Organic Heart Disease
ArteriosclerosisINTERVAL BETWEEN
ONSET AND DEATHConditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour
a.m.
p.m.20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 11/1/62 to 11/11/62 and last saw him alive on 11/11/62
Death occurred at 8:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

burial

11/15/62

Ozark Mem. Cemetery

Branson, Mo

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

Walter Cobb Branson, Mo

11/17/62

Robert Campbell

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

VS 300
Rev. 4/59

1060

29350

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NOV 21 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Walter Cal

Licensed Embalmer No. 4731

P. O. Address Bismarck ND

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.